Steady growth in antiretroviral treatment provision by disease management and community treatment programmes

Leigh F Johnson, Heather D McLeod

To the Editor: Although access to highly active antiretroviral treatment (HAART) in the South African public health sector is closely monitored,[1] much remains unknown regarding the numbers of HIV-positive individuals receiving HAART outside the public health sector. Access to HAART in the private health sector is probably considerably better than in the public health sector, as private sector patients can often afford the costs of HAART, and many are beneficiaries of medical schemes, which are required to provide HAART to eligible beneficiaries as a prescribed minimum benefit. An investigation conducted in 2005 found that by the middle of 2005, at least 50 000 South Africans were receiving HAART through disease management programmes (DMPs), workplace treatment programmes (all of which are administered by DMPs) or community treatment programmes.[2] This investigation was repeated in 2006, with the objective of estimating the numbers of people receiving HAART by mid-2006 and the rate of growth in numbers on treatment between 2005 and 2006.

Method

A list of all DMPs and community treatment programmes providing HAART was compiled, in consultation with the AIDS Law Project and key informants in the private health sector. Seventeen disease management programmes (Aganang, Aid for AIDS, Aurum Health, Calibre, CareWorks, Discovery, Freeway Direct, Lifesense, Lifeworks, Medicover, Old Mutual, Prime Cure, Q.A. Care Plus, Qualsa, Right to Care, Status, Yebo Life) and 10 community treatment programmes (managed by Right to Care, the South African Catholic Bishops Conference and the Treatment Action Campaign) were contacted.

Results

With the exception of 4 DMPs, all treatment programmes provided numbers that could be used to estimate the number of patients on HAART by mid-2006. The overall response rate was therefore 85% of programmes (76% if only the DMPs were considered). Results of the investigation are summarised in Table I. The 13 DMPs that responded were treating a total of 55 900 patients by mid-2006. The DMP market is concentrated, with 46 800 of this total being managed by the 5 largest programmes. The DMPs that account for the highest proportions of this total are Aid for AIDS (36%), Lifesense (15%), Discovery Health (11%), Aurum Health (11%) and Qualsa (11%). Although these numbers have not been adjusted to reflect the 4 DMPs that did not respond, the non-responding DMPs are believed to be treating relatively small numbers of patients (probably less than 5 000 altogether).

Community treatment programmes were treating approximately 11 600 patients with HAART by mid-2006. Adding these to the numbers treated by DMPs, the estimated total number of individuals receiving HAART through DMPs or community treatment programmes by mid-2006 is estimated to be at least 67 600.

For those programmes that supplied estimates both in 2005 and 2006 (10 DMPs and 9 community treatment programmes), annualised growth rates in numbers on treatment were calculated. When weighted by the estimated number on treatment in mid-2005, the average growth rate was 32%. The weighted average growth rate was lowest among the 5 largest DMPs (26%), higher among the smaller DMPs (37%) and highest among the community treatment programmes (62%). The higher growth rate among community treatment programmes is probably due to these programmes having been established relatively recently and therefore having to cater to a much greater unmet treatment need.

Discussion

These estimates of numbers on HAART are substantially higher than those submitted by medical schemes to the Risk Equalisation Fund (REF), which totalled 32 844 in June 2005. However, the REF sets out strict conditions under which a medical scheme receives reimbursement for someone identified with a chronic disease. These REF Verification Criteria require not only that a person is identified through ICD-10 coding as having that chronic disease but that the person is also shown to have been receiving treatment in at least 2 of the previous 3 months. In a study of the beneficiaries of the four largest medical scheme administrators (representing 63.4% of all medical scheme beneficiaries in 2005), it was found that the number of beneficiaries eligible for HAART in terms of the national antiretroviral guidelines[3] was substantially greater than the number eligible for payment from the REF. Extending the REF study figures to the industry as a whole, it is estimated that in 2005 there were 59 671 medical scheme beneficiaries

Centre for Actuarial Research, University of Cape Town
Leigh F Johnson, BBusSc, PGDipActSc, FASSA

Department of Public Health and Family Medicine, University of Cape Town, and Department of Statistics and Actuarial Science, Stellenbosch University
Heather D McLeod, BBusSc, FIA, CFA, FASSA

Corresponding author: *L Johnson (Leigh.Johnson@uct.ac.za)*

Table I. Numbers on antiretroviral treatment and annualised growth rates

	Response rate (N)	Number on HAART*	Growth rate (weighted average)
Five largest DMPs	100% (5)	46 800	26%
Remaining DMPs	67% (12)	9 100†	37%
All DMPs	76% (17)	55 900†	27%
Community treatment programmes	100% (10)	11 600	62%
All treatment programmes	85% (27)	67 600†	32%

* Numbers rounded to the nearest 100, since several programmes did not provide exact estimates.
† Excluding four DMPs for which no estimates were provided.

identified with HIV in terms of the national antiretroviral guidelines, and that 25 680 should have been eligible for payments from REF. (The latter figure was estimated using the REF Entry and Verification Criteria v2, due to be implemented by all administrators from 1 January 2007.) The relatively low numbers on HAART that are regularly reported by REF therefore appear to be a consequence of the strict requirements for reimbursement from the REF, rather than low HAART uptake.

The numbers estimated here need to be seen in the light of the roughly 181 000 people who had started HAART in the public health sector by June 2006, and the trebling in numbers cumulatively enrolled on treatment in the public health sector between mid-2005 and mid-2006.[1] The private and NGO sectors contribute significantly to the national effort to expand access to HAART, though the higher rates of growth achieved in the public health sector imply that the contribution of the private and NGO sectors is likely to become increasingly small relative to that of the public health sector. No attempt has been made to estimate the number of individuals who are currently paying for their own treatment and not belonging to DMPs, community treatment programmes or public sector programmes. These numbers will need to be estimated in future, through surveys of general practitioners or studies of antiretroviral drug sales, in order to obtain a more complete picture of antiretroviral access outside the public health sector.

1. Department of Health. National Comprehensive HIV and AIDS Plan Statistics. 2006. http://www.doh.gov.za/docs/statistics-f.html (accessed 1 December 2006).
2. Johnson LF. Estimated numbers of patients on antiretroviral treatment in the South African private health sector. *AIDS Analysis Africa Online* 2006; Jan/Feb: 4-6.
3. Department of Health. Operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa. 2003. http://www.info.gov.za/otherdocs/2003/aidsplan.pdf (accessed 28 November 2003).